Aetna Universal Insurance Sdn Bhd v Fanny Foo May Wan

HIGH COURT (KUALA LUMPUR) — CIVIL APPEAL NO R2–12–123 OF 1996
FAIZA TAMBY CHIK J
27 JUNE 2000

Evidence *— Adverse inference — Failure to call witness — Relevant documents agreed upon — Failure to call makers of documents — Whether adverse inference invoked against defendant for not calling witnesses*

Insurance *— Life insurance — Duty of disclosure — Material facts — Failure to disclose health risk — Deceased died of road accident, whether deceased's case was a medical case — Whether non-disclosure of material fact allows insurer to avoid contract*

Insurance *— Life insurance — Formation of contract and commencement of cover — Conditions of payment in proposal form and conditional receipt — Policy not accepted yet at time of death — Whether policy in existence*

The defendant/appellant was a licensed insurer. The plaintiff/respondent was the lawful representative of Foo Chee Tuck, deceased ('the deceased'). By a proposal form and a 'Statement to the Medical Examiner' dated 2 January 1991, the deceased applied to the defendant for a life insurance policy and a supplementary rider. A medical report was obtained to process the deceased's application. Pending the processing of the deceased's application and to acknowledge receipt of the first two months' premium, the deceased was issued with a conditional receipt dated 2 January 1991. The deceased died on 7 January 1991 as a result of a motor vehicle accident before his application to the appellant was accepted. The plaintiff claimed for the amount insured under the policy and the supplementary rider and this was allowed by the sessions court. The relevant documents had all been agreed to. The defendant appealed. The issues raised were: (i) whether there was non-disclosure of the fact that prior to the application by the deceased, the deceased had medical tests conducted on him; and (ii) no policy was in existence at the time of the deceased's death, therefore no monies were payable to the plaintiff.

Held, allowing the appeal with costs:

(1) There had been a misstatement in the statement to the medical examiner which together with the proposal form formed the basis of the contract and consequently by operation of law, the contract may be avoided ab initio by the defendant. The general principle that an insurance contract is a *uberrimae fidei* contract which imposes a duty on the proposed insured to exercise the utmost good faith and to make a full disclosure of all facts material to the contract remains applicable. The risk being insured against was

the deceased's death. The health of a proposed insured must be a material fact when ascertaining the risk of insuring against his death (see pp 233E–F, 234B).

(2) By reason of the deceased's untimely death, at which the deceased's application was still being processed, the defendant had not as yet accepted the offer made by the deceased through his proposal form. Therefore a contractual nexus between the defendant (as insurer) and the plaintiff (as insured) had not as yet come into fruition (see p 236G).

(3) The sessions court judge was wrong to hold that the deceased's case was not a medical case. The mere fact that a medical report was obtained as a result of the deceased's application for insurance coverage demonstrated that the deceased was a medical case (see p 238H, 239A–B).

(4) The sessions court judge was in error for invoking s 114(g) of the Evidence Act 1950 against the defendant for not calling a host of witnesses. She had failed to appreciate that the relevant documents had all been agreed to. In other words, there was no necessity to call the makers of such documents (see p 240D).

[**Bahasa Malaysia summary**

Defendan/perayu adalah penanggung insurans yang berlesen. Plaintif/responden merupakan wakil sah Foo Chee Tuck, simati ('simati'). Melalui borang cadangan dan satu 'Penyata kepada Pemeriksa Perubatan' yang bertarikh 2 Januari 1991, simati telah memohon kepada defendan untuk satu polisi insurans hayat dan satu pemegangan tambahan (supplementary rider). Sementara menunggu pemprosesan permohonan simati dan sebagai pengakuan penerimaan premium dua bulan pertama, simati telah diberi resit bersyarat yang bertarikh 2 Januari 1991. Simati meninggal dunia pada 7 Januari 1991 disebabkan oleh kemalangan jalan raya sebelum permohonannya dapat diterima. Plaintif menuntut jumlah wang di bawah polisi dan pemegangan tambahan tersebut, dan ini dibenarkan oleh mahkamah sesyen. Segala dokumen-dokumen yang relevan telah disetujui. Defendan merayu. Isu-isu yang dibangkitkan adalah: (i) sama ada terdapat ketidakdedahan fakta bahawa simati telah menjalankan pemeriksaan perubatan sebelum membuat permohonannya; dan (ii) polisi tersebut tidak wujud ketika simati meninggal dunia, dan oleh itu tiada wang yang dapat dibayar kepada plaintif.

Diputuskan, membenarkan rayuan tersebut dengan kos:

(1) Terdapat pernyataan silap di dalam penyata kepada pemeriksa perubatan yang, bersama dengan borang cadangan, membentuk asas kepada perjanjian tersebut. Oleh itu, perjanjian tersebut boleh dibatalkan oleh defendan ab initio. Prinsip yang menyatakan bahawa perjanjian insurans merupakan perjanjian

uberrimae fidei yang mengenakan kewajipan ke atas pihak pengambil insurans yang dicadangkan supaya mengamalkan niat mulia dan supaya membuat pendedahan sepenuhnya fakta-fakta perjanjian yang material, masih dipakai. Risiko yang telah diinsuranskan adalah kematian simati. Kesihatan pengambil insurans yang dicadangkan merupakan fakta yang material ketika memastikan risiko menginsuranskan kematiannya (lihat ms 233E–F, 234B).

(2) Oleh kerana simati meninggal dunia dengan tidak diduga, dan permohonannya masih sedang diproses, defendan masih belum menerima tawaran simati melalui borang cadangannya, dan hubungan perjanjian di antara defendan (sebagai penanggung insurans) dan plaintif (sebagai pengambil insurans) tidak wujud (lihat ms 236).

(3) Hakim mahkamah sesyen telah khilaf dalam memutuskan bahawa kes defendan bukan merupakan kes perubatan. Oleh kerana laporan perubatan telah diterima ketika simati memberi permohonannya, ini menunjukkan bahawa kes ini adalah kes perubatan (lihat ms 238H, 239A–B).

(4) Hakim mahkamah sesyen telah khilaf dalam menggunakan s 114(g) Akta Keterangan 1950 terhadap defendan kerana defendan tidak memanggil saksi-saksi tertentu. Beliau gagal menyedari bahawa segala dokumen-dokumen yang relevan telah disetujui dan oleh itu, pembuat dokumen-dokumen tersebut tidak perlu dipanggil (lihat ms 240D).]

Notes

For cases on duty of disclosure, see 8 *Mallal's Digest* (4th Ed, 1999 Reissue) paras 42–61 and 116.

For cases on adverse inference for failure to call witness, see 7 *Mallal's Digest* (4th Ed, 1998 Reissue) paras 116–129.

For cases on formation of contract and commencement of cover for life insurance, see 8 *Mallal's Digest* (4th Ed, 1999 Reissue) paras 117–118.

Cases referred to

Anderson Samuel v Ann Fitzgerald (1853) 4 HLC 484 (refd)

Borhanuddin bin Haji Jantara & Anor v American International Assurance Co Ltd [1987] 1 MLJ 22 (refd)

Condogianis v Guardian Assce Co Ltd [1921] 2 AC 125 (refd)

Duckett v Williams (1834) 2 Cr & M 348 (refd)

Joel v Law Union and Crown Insurance Co [1908] 2 KB 863 (refd)

Lambert v Co-operative Insurance Society Ltd [1975] 2 Lloyd's Rep 485 (refd)

Loh Sai Nyah, Madam v American International Assurance Co Ltd [1998] 2 MLJ 310 (refd)

March Cabaret Club & Casino Ltd v London Assurance Ltd [1975] 1 Lloyds Rep 169 (refd)
New India Assurance Co Ltd v Pang Piang Chong & Anor [1971] 2 MLJ 34 (refd)
Ong Eng Chai v China Insurance Co Ltd [1974] 1 MLJ 82 (refd)
Rust v Abbey Life Insurance Co Ltd [1979] 2 Lloyds Rep 334 (refd)
United Malayan Insurance Co Ltd v Lee Yoon Heng [1964] MLJ 453 (refd)

Appeal from: Summons No 52–4272–1993 (Sessions Court, Kuala Lumpur)

Wong Hock Mun (*Azim Tunku Farik & Wong*) for the appellant.
James Edwin (*James Edwin & Co*) for the respondent.

Faiza Tamby Chik J. : This appeal is against the decision of the learned sessions court judge given on 22 April 1996, who after a full trial granted judgment as prayed to the plaintiff. A copy of the judgment appealed against is annexed to the 'rekod rayuan tambahan'. The grounds of judgment of the learned sessions court judge (at pp 230–240 of the record of appeal) were delivered some two years ten months after her decision. The relevant pleadings are: The plaintiff's summons dated 13 December 1993 (pp 224–229 of the record of appeal, the re-amended defence dated 26 October 1994 (pp 218–221 of the record of appeal), the documents tendered as exhibits to the court below are at Part C of the record of appeal (pp 260–309 of the record of appeal).

In gist, the facts are as follows: The defendant is a licensed insurer. The plaintiff is the daughter and lawful representative of Foo Chee Tuck, deceased ('the deceased'). By a proposal form dated 2 January 1991 (pp 283–284 of the record of appeal) and a 'statement to the medical examiner' of the same date (pp 286–287 of the record of appeal), the deceased applied to the defendant for a life insurance policy. The policy applied for was for an mount of RM40,000 (basic life) together with a supplementary rider of RM40,000. Pending the processing of the deceased's application and to acknowledge receipt of the first two months' premium, the deceased was issued with a conditional receipt also dated 2 January 1991 (p 285 of the record of appeal). The deceased died on 7 January 1991 aged 48 years as a result of a motor vehicle accident before his application to the appellant was accepted. The plaintiff as the deceased's nominated beneficiary is now claiming (grounding her claim in contract) from the defendant payment of the full insured amount applied for of RM80,000. The defendant maintained that there was no sum payable on the policy to the plaintiff and based its defence on two separate and distinct grounds, namely that the deceased had made an inaccurate or incorrect statement in his 'statement to the medical examiner' which formed part of his proposal form, thus entitling the defendant as insurer to avoid the policy ab initio (the 'Non-Disclosure' ground). This is pleaded at paras 4, 5 6 and 7 of the re-amended defence. Alternatively, no policy was in existence at the time of the deceased's death (the insured event) and therefore no monies are payable to the plaintiff (the 'Non-Existence of Policy' ground). A policy

would have existed only in the event that the deceased met with the specific conditions imposed by para A of the conditional receipt. In such an event, the conditional receipt deemed the policy to exist retrospectively to the date of the conditional receipt. The deceased did not meet with the said specific conditions. (This is pleaded at paras 8 and 9 of the re-amended defence).

The first ground of defence is that of non-disclosure. The facts required to bear out this ground of defence are all agreed facts, in that they are from documents which have all been agreed to. They are as follows: The following words are found at the bottom of the 'statement to the medical examiner' (at pp 286–287 of the record of appeal):

> I affirm that the above answers were given by me in reply to the questions put to me, confirm that they are full, complete and true and agree that they are a continuation of, and form part of my application and that the foregoing answers shall also form part of any policy contract that may be issued on the strength thereof.

The effect of this clause is, inter alia, to incorporate the answers given in this statement as part of the proposal to the appellant. The following words are found at part IV of the proposal form (at p 284 of the record of appeal):

> (b) All the foregoing statements and answers in this application together with those in any required medical examination, questionnaire or amendments, are full complete and true, and I understand that the Company, believing them to be such, will rely and act on them.
>
> I/We further declare that the information contained in this proposal forms the sole basis for the issuance of the policy.

The effect of these two clauses is to make the answers in the statement to the medical examiner the basis of the contract. It is observed that if reference is made to the statement to the medical examiner dated 2 January 1991 (pp 286–287 of the record of appeal) at para 6 and in relation to the question 'In the past five years, have you had any: (a) diagnostic tests such as x-ray, electrocardiogram or blood study including blood tests for AIDS and its related conditions?'; the deceased answered 'No'. The medical report of Dr Joseph Ong (at pp 288–290 of the record of appeal) stated expressly that the deceased had tests conducted on him (sometime in October 1989) including x-ray, electrocardiogram and a blood study. The answer given by the deceased was therefore incorrect and untrue. It must be stressed that the above are facts gleaned from agreed documents. These facts are therefore not in issue. There is at common law no legal obligation on a contractor to make a voluntary disclosure of information to the other party. However, an insurance contract is a *uberrimae fidei* contract which imposes a duty on the proposed insured to exercise the utmost good faith and to make a full disclosure of all facts material to the contract. In *March Cabaret Club & Casino Ltd v London Assurance Ltd* [1975] 1 Lloyds Rep 169 at p 175, Mr Justice May said:

> Bearing in mind the basis of the rule however, which is, as Lord Justice Scrutton pointed out, the fact that there is a disparity in negotiating position between the intending assured and insurers, in my judgment the duty to disclose is not based upon an implied term in the contract of insurance at all;

it arises outside the contract; it applies to all contracts uberrimae fidei and is not limited to insurance contracts; it also applies, for instance, to contracts of partnership, contracts of surety, certain family settlement contracts and other similar types of contractual relationship.

Given the rule, what circumstances or facts are in truth material so as to require disclosure to insurers? On the authorities, two tests seem to emerge. The first is set out in sub-s (2) of s 18 of the Marine Insurance Act:

> Every circumstance is material which would influence the judgment of a prudent insurer in fixing the premium, or determining whether he will take the risk.

The other test may be described as the 'reasonable assure test' and was referred to in Lord Justice Fletcher Moulton's judgment in *Joel v Law Union and Crown Insurance Co* [1908] 2 KB 863 at p 883, a passage on which Mr Beldam particular relied:

> There is therefore something more than an obligation to treat the insurer honestly and frankly, and freely to tell him what the applicant thinks it is material he should know. That duty, no doubt, must be performed, it does not suffice that the applicant should bona fide have performed it to the best of his understanding. There is the further duty that he should do it to the extent that a reasonable man would have done it, and if he has fallen short of that by reason of his bona fide, considering the matter not material, whereas the jury, as representing what a reasonable man would think, hold that it was material, he has failed in his duty, and the policy is avoided.

Therefore, it can be seen that the statement to the medical examiner forms part of the proposal form and was subject to the basis clause contained therein. The express terms quoted above, both in the statement to the medical examiner and the proposal form itself, stated that both the documents form part and parcel of the same application. Indeed, both documents were completed on the same day. Reference was expressly made in the Proposal Form to the effect that the answers in any medical examination form part of the proposal. The legal effect of a basis clause in a proposal form is that it entitles the insurer to avoid the contract simply by showing that the statement was inaccurate or incorrect. The following principles apply:

(i) There is no necessity to show that the misstatement is material to the risk insured. In *Anderson Samuel v Ann Fitzgerald* (1853) 4 HLC 484, the court held that the representation being part of the contract, its truth, not its materiality was in question;

(ii) The knowledge of an insured as to the truth of a statement is irrelevant. As such, we are not concerned at all with the mens rea of the insured but only whether the alleged statement is correct. In *Duckett v Williams* (1834) 2 Cr & M 348:

> By a declaration and statement as to health, etc signed by the assured, previous to effecting a policy on a life, it was agreed, that, if any untrue averment was contained therein, or if the facts required to be set forth in the proposal annexed were not truly stated, the premiums should be forfeited, and the assurance be absolutely null and void. The statement

as to the health of the life was untrue in point of fact, but not to the knowledge of the party making it: — Held the premiums were forfeited, and could not be recovered back.

(iii) An insurer is entitled to reply on the misstatement even though it was made inadvertently. In *Condogianis v Guardian Assce Co Ltd* [1921] 2 AC 125 it was held:

Held, (1)the answer was untrue, since the question could not reasonably be read as being intended to have the limited scope which would render the answer true; (2)that there was a breach of warranty, whether or not the misrepresentation was as to a material fact; and (3)appellant could not recover on the policy.

Judgment of the High Court affirmed.

The principles enunciated in the above quoted English cases have been accepted by our courts. In *Ong Eng Chai v China Insurance Co Ltd* [1974] 1 MLJ 82:

The plaintiff claimed under a policy of insurance in respect of his car. The defendants pleaded that the policy was void as the proposal form contained untrue statements and answers. The proposal form had been filled in and signed by an agent of the defendant's company and it contained untrue answers to the question whether any previous insurance had been declined, refused or cancelled.

Held: (1) the untrue answers to the questions entitled the defendant company to avoid the contract;

(2) in the circumstances the agent of the company, when he signed the proposal form, did so as the agent of the plaintiff and therefore the plaintiff was bound.

By reason of the matters aforesaid, I hold in favour of the defendant as it was uncontroverted that there had been a misstatement in the statement to the medical examiner which together with the proposal form formed the basis of the contract and consequently, by operation of law, the contract may be avoided ab initio by the defendant. The general principle that an insurance contract is a *uberrimae fidei* contract which imposes a duty on the proposed insured to exercise the utmost good faith and to make a full disclosure of all facts material to the contract remains applicable. The difference between proposals containing a basis clause and ones without is that in the latter category an insurer is obliged to show that the misstatement was of a material fact or that it was fraudulent before he is entitled to avoid liability under the policy. In *Joel v Law Union and Crown Insurance Co* [1908] 2 KB 863, it was decided by the English Court of Appeal that when the facts misstated by an insured in a proposal form did not form part of the basis of the contract, the insurer was bound to show that the facts were material before he was entitled to avoid the policy. The above statements of law have been followed in Malaysia. In *New India Assurance Co Ltd v Pang Piang Chong & Anor* [1971] 2 MLJ 34, where the court held:

(2) the first defendant's answer to the question did not constitute a non-disclosure of a material fact or representation of a fact which was false in some material particular.

In *United Malayan Insurance Co Ltd v Lee Yoon Heng* [1964] MLJ 453 the court held:

> Held: the plaintiffs were entitled to avoid the policy on the ground that it was obtained by non-disclosure of material fact or by a representation of fact which was false in some material particular.

In the instant case, the deceased stated that he had not had in the past five years, any diagnostic tests such as x-ray, electrocardiogram or blood study when in fact he had such tests not more than 18 months ago. The aforementioned tests were relevant to his health. The risk being insured against was the deceased's death. The health of a proposed insured must be a material fact when ascertaining the risk of insuring against his death. This, I think, would be trite. In *Lambert v Co-operative Insurance Society Ltd* [1975] 2 Lloyd's Rep 485, MacKenna J stated:

> Everyone agrees that the assured is under a duty of disclosure and that the duty is the same when he is applying for a renewal as it is when he is applying for the original policy. The extent of that duty is the matter in controversy. There are, at least in theory, four possible rules or tests which I shall state. (1) The duty is to disclose such facts only as the particular assured believes to be material. (2) It is to disclose such facts as a reasonable man would believe to be material. (3) It is to disclose such facts as the particular insurer would regard as material. (4) It is to disclose such facts as a reasonable or prudent insurer might have treated as immaterial.
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> Their Lordships decided in favour of the fourth test after taking into account the fact that the same standard had been adopted by two Acts of Parliament, namely, the Marine Insurance Act 1906 and the Road Traffic Act 1934.

Therefore, the evidence of the defendant's witnesses indicate that the health of the proposed insured in the underwriting process was relevant:

(a) to the decision whether or not to insure the proposed insured (thus the deceased's application for the rider ('LLR') would have been rejected as he was of sub-standard medical risk);

(b) to the decision as to the amount of premium to be charged (thus the fact that the deceased would have been charged premium at a higher than standard rate).

Following from the above, the misstatement on the part of the deceased was material in nature. The defendant was therefore entitled to avoid the contract of insurance.

The second ground of defence is that of non-existence of the policy. The conditional receipt itself is an agreed document (p 261 of the record of appeal). By virtue of the fact that condition A of the said receipt is of paramount importance, I take the liberty of quoting it in toto which is:

> If, at the date of completion and signing of the proposal form or statement to the medical examiner, whichever is the latter, the proposed insured was acceptable and insurable under the company's rules and practice of selection, of which the company shall be the sole judge, for the amount and plan of life insurance and any additional benefits applied for at the company's standard

rate applied for such insurance, then the coverage applied for shall, subject to the limitations described in B below and subject to the provisions of the policy and supplementary contracts that may be issued by the company on the basis of the application, be deemed to take effect from the date hereof.

Evidence relevant to this so called Non-Existence of Policy ground was led through, inter alia, Encik Hafidz bin Hj Mohd Baki to the following effect: That he is at present the underwriting manager of the defendant. As at January 1991, that is at the time the deceased's application was being processed, he was an underwriting executive with the defendant. Although, he was not directly involved with the processing of the deceased's application, his duties were to process (underwrite) applications to the defendant for life insurance. He therefore was conversant with the procedures to the defendant and its rules and practice in assessing and processing (the underwriting process) applications for life insurance. He further stated that he was very well aware of the facts and circumstances surrounding the deceased's particular case. The test applied by an underwriter of life insurance in assessing the insurability of a particular insured is threefold, namely: (i) the occupational risks; (ii) the medical risks; and (iii) the financial risks. In his assessment of the risks in insuring the deceased, basing the same on the facts contained in:

(a) The proposal form (at pp 283–284 of the record of appeal);

(b) The statement to the medical examiner (at at pp 286–287 of the record of appeal);

(c) The letter from Dr Joseph Ong (pp 288–290 of the record of appeal).

And being guided by the defendant's underwriting manual ratings (pp 302–308 of the record of appeal), he was of the opinion that, inter alia, the deceased was medically of a sub-standard risk due to his suffering from ischaemic heart disease. By reason of the deceased being of a sub-standard medical risk, the deceased would not have been insured at the defendant's standard rate. The deceased's application for basic life coverage of RM40,000 would have been accepted but with the provision of an increased premium being payable. As for the deceased's application for the living life rider (LLR) of RM40,000, this would not have been accepted by the defendant as it was the policy of the defendant not to accept riders from applicants of sub-standard risk. The deceased's application was still being processed at the time of the deceased's death on 7 January 1995. Apparently, the details of his application were still being keyed into the defendant's computer (data entry). The defendant's did not have time to communicate with the deceased as regards the latter's application.

Evidence relevant to this so called Non-existence of Policy ground was also led through Dr Nirmala Menon to the following effect. She is at present the medical director and vice-president of the defendant. She has been with the defendant since October 1990. Her degree in medicine was obtained in 1983 and her postgraduate qualifications in renal medicine obtained in 1987 and in insurance medicine in 1992. She has previously given evidence in court which evidence had been accepted by the court. Her duties

including those in relation to this particular case was defined by her to be rendering opinions on 'medically sub-standard' lives and defining the overall rating for that particular life. Her conclusion as regards the deceased was that he was not of standard risk but of a medically sub-standard risk. This conclusion was reached after having considered the following:

(a) the letter/report from Dr Joseph Ong (pp 265–267 of the record of appeal) states that the deceased was admitted to Assunta Hospital from 9 to 13 October 1989 after having complained of chest pains;

(b) the deceased was investigated thoroughly and found to be suffering from hypertension and ischaemic heart disease;

(c) he had been prescribed Nitroderm, Minipress and Herbesser for the treatment of his hypertension and ischaemic heart disease.

The deceased in signing the proposal form has also agreed that 'The insurance herein applied for shall not take effect unless and until a policy is issued … however, that if any payment of premium is made in cash … the terms of the receipt shall apply hereto and are agreed to' (please refer to para 3 of the clause headed: 'Declaration and Authorization' at p 284 of the record of appeal). Thus the deceased has expressly agreed to be bound by the terms of the conditional receipt.

The dispute in question has, at its axis, an alleged contract of insurance. A contract of insurance is subject to the rules normally applicable to contracts in general, save for certain exceptions which I will highlight where relevant. Thus, such contracts to be valid must have the oft quoted elements of offer and acceptance, consideration and certainty. In terms of contracts of insurance, the submission by the proposed insured to the insurer of the proposal form is considered to be the offer. A contract of insurance comes into being only when the proposal is accepted by the insurer. Thus in *Rust v Abbey Life Insurance Co Ltd* [1979] 2 Lloyds Rep 334, it was decided, inter alia, by the English High Court and upheld by the Court of Appeal that a contract between an insured and an insurer was concluded when the insurer accepted an application made by the insured. Applying the law to the facts of the instant case, I am of the opinion that by reason of the deceased's untimely death, at which time the deceased's application was still being processed, the defendant had not as yet accepted the offer made by the deceased through his proposal form. Therefore a contractual nexus between the defendant (as insurer) and the plaintiff (as insured) had not as yet come into fruition. The matter however did not rest there. Although, at first blush a contractual nexus between the defendant (as insurer) and the plaintiff (as insured) did not exist, the issuance of the conditional receipt by the defendant acknowledging the receipt of RM563.46 (estimated premium for the first two months at the 'standard rate') complicated but eventually did not alter matters. Condition A of the conditional receipt states:

> If, …, the proposed insured was acceptable and insurable under the company's rules and practice of selection, of which the company shall be the sole judge, for the amount and plan of life insurance and any additional benefits applied for at the company's standard rate applied for such insurance;

A then the coverage applied for shall, … be deemed to take effect from the date hereof.

Simplified, condition A of the conditional receipt has the effect of backdating the coverage of and over the deceased's life to 2 January 1991 and consequently imposing liability on the appellant to make payment in
B the event of the former's death if the following conditions were met:

(i) The deceased must have been acceptable and insurable under the defendant's rules and practice of selection, for the amount and plan of life insurance and any additional benefits he has applied for at the defendant's standard rate;

C (ii) The decision whether the deceased was acceptable and insurable at the defendant's standard rate is the sole province of the defendant.

Bearing in mind the conditions above and the testimony of both witnesses of the defendant that the deceased was of a sub-standard medical risk and thus would not have been insured at the standard rate, it was clear that the
D requirements imposed by condition A of the conditional receipt to cause the coverage applied for to be backdated had not been fulfilled. Even if the decision regarding the deceased's insurability was not expressed to be the sole province of the defendant, the evidence as regards the deceased being rated sub-standard medically was never contradicted by the evidence by the plaintiff nor was it ever put to the defendant's witnesses in cross-
E examination that this was not the case. In the case of *Borhanuddin bin Haji Jantara & Anor v American International Assurance Co Ltd* [1987] 1 MLJ 22 wherein the material terms contained in the proposal form there are on all fours to the proposal form in the instant case. There the Supreme Court ruled that the insurance monies were payable. The brief facts of the case are as follows:

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(i) On 21 November 1977, the deceased submitted a proposal form to AIA;

(ii) Subsequently on 2 December 1977, the deceased made payment of the first premium to AIA and was duly issued with a conditional
G receipt;

(iii) The deceased was killed in a plane crash on 4 December 1977.

AIA, in declining payment, relied on certain terms contained in the conditional receipt. The Supreme Court in allowing the claim rejected AIA's contention on the grounds that in constructing condition (c) of the
H proposal form, (which is in pari materia with the proposal form of the instant case) that is '… Provided, however, that if any payment of premium is made in cash at the time of signing this application and a conditional receipt is issued therefor, the terms of the receipt shall apply hereto and are agreed to', due to the proposal form and conditional receipt not being contemporaneous, the terms of the conditional receipt did not apply, and
I there were no further hurdles to be cleared by the deceased, and AIA would have had to issue the policy if she had not died. The conclusion reached by the Supreme Court in *Borhanuddin*'s case is based on facts which are,

crucially in some aspects disparate, to those of the instant case, namely in the instant case, the proposal form (together with the statement to medical examiner) and the premium for the first two months (based on the 'standard rate') was received on 2 January 1991 and the conditional receipt was issued contemporaneously, in that it was issued on the same date itself. Thus, the terms of the conditional receipt must apply. In the words of Salleh Abas LP, '… the deceased was exempted from the requirements of a medical check up. There was nothing left for the deceased to do before the respondents could issue and deliver the policy.' In the instant case, the deceased's age and health was such that he was still subject to medical investigations which revealed that the deceased could only be insured for basic life (RM40,000) on a premium above the appellant's standard rate; and not insurable at all as regards the rider (LLR). In other words, the terms of the proposed insurance contract of the instant case, unlike *Borhanuddin's* case, had yet to be finalised. I am of the opinion that the construction of the terms of the proposal form in *Borhanuddin's* case by the Supreme Court lends credence and reinforces the defendant's case in the following way:

(i) The Supreme Court's finding that he lacked contemporaneity between the proposal form and the conditional receipt negates the applicability of the terms of the conditional receipt. Conversely, if the element of contemporaneity exists (which it does in the instant case), it must follow that the terms of the conditional receipt applies;

(ii) The Supreme Court also found that as AIA would have issued the policy if the deceased had not died on the same terms as applied for in the deceased's proposal form, the contract had been concluded as all that was left to do was purely administrative. Conversely as the defendant here was still deciding whether or not to issue the policy applied for by the deceased, and if so at what premium and on what terms, the contract cannot be said to have been concluded and thus to be in existence.

The reasoned judgment of the learned sessions court judge is at pp 230–240 of the record of appeal. The judgment can be attacked based on the following reasons. Firstly, at p 232 of the record of appeal, paras B and C, the learned sessions court judge in referring to the proposal form (pp 283–284 of the record of appeal) stated:

> I also noted that under the heading 'Part II' is stated 'For Non-Medical Cases, answer 18 to 25. For medical cases, do not answer questions 28 to 25'. I observed that questions 18 to 25 had been crossed out with a note stating 'Refer to Medical Report'. This means that this is a 'Non-Medical' case'.

The learned sessions court judge's interpretation of the deletion of questions 18 to 25 with the comment 'Refer to Medical Report' was wrong. Thus, her reasoning and deduction that this was a 'Non Medical' case was also wrong for the following reasons. A perusal of questions 18–25 at p 283 of the record of appeal will show that the same have not been answered. As the form states 'For Medical cases, Do not answer questions 18 to 25', and the same have not been answered, the deceased's case must be a 'medical

A case'. It is perverse to hold that although a medical report was obtained incurring extra costs and inconvenience, the deceased could still be categorized as a 'non-medical case'. If the deceased was a 'non-medical case', all that he needed to do was to answer questions 18 to 25. Why go to such lengths if the deceased was a 'non-medical case'. The mere fact that a medical report was obtained as a result of the deceased's application for insurance coverage by itself demonstrated that the deceased was a medical case.

Secondly, at para C on p 233 of the record of appeal, the learned sessions court judge held that 'the terms of the receipt shall apply hereto and are agreed to', a finding with which I agree. In holding the defendant liable at para C on p 234 of the record of appeal because the deceased died of an accident and not illness or disease, the learned sessions court judge stated that she was relying on para B of the conditional receipt (p 285 of the record of appeal). This was clearly an error of law as para B of the conditional receipt (p 285 of the record of appeal) is a limiting provision in that it limits the extent of the defendant's liability as insurer. Before para B of the conditional receipt can have any effect, the pre-condition is that the defendant's liability did exist ie the insurance policy must be in existence and have come alive. Otherwise, there was no liability to limit. Thus, the learned sessions court judge has jumped the gun in examining para B before para A. It is para A that determines whether there is any coverage in the first place. No where in her judgment has the learned sessions court judge examined or even mentioned para A. This is a fundamental error on her part. In the event that the learned sessions court judge has given effect to para A, she would have found that the policy was not in existence.

Thirdly, the learned sessions court judge has also in her judgment at paras A and B of p 234 of the record of appeal held that '… the insurance agent's (sic) having accepted the premium and issuing a receipt thereafter indicates that the insurance agent was the agent of the company, ie the defendant, and any transaction which has been concluded between the deceased and such agent would be binding on the defendant.'. This statement by the learned sessions court judge is incorrect. It is observed that the decision of the Court of Appeal in *Madam Loh Sai Nyah v American International Assurance Co Ltd* [1998] 2 MLJ 310 was delivered after submissions were received by her. It is noted that in *Loh Sai Nyah* the Court of Appeal was presiding over a case with remarkably similar facts to those in the instant case and rejected the insured's claim on, inter alia, the ground that (at p 315D–E):

> Boo was only an ordinary agent of the respondent. The learned Sessions Court Judge had referred to *Linford v The Provincial Horse and Cattle Insurance Co* SC 10 Jur (NS) 1066; 11 LT 3301 where it was held that an ordinary local agent of an insurance company is not, without special authority, authorised to bind the company by a contract to grant a policy …

At p 320E:

> Especially so since we had found that Boo had no authority to contract on behalf of the respondent, … .

Fourthly, para 6 of the statement to medical examiner reads as follows:

> In the past five years, have you had any:
>
> (a) diagnostic test such as x-ray, electrocardiogram or blood study including blood tests for AIDS and its related conditions?
>
> (b) illness, injury, operation, medical advice, hospital treatment or physical check-ups not mentioned above?

At the bottom of p 235 of the record of appeal, the learned sessions court judge held in relation to 6(a) that the paragraph must be read conjunctively to mean that the x-ray, electrocardiogram or blood study must be only those that pertain to AIDS. This is incorrect because in the natural meaning of things, the effect of the word 'including' at 6(a) must mean that the tests concerned are not solely pertaining to AIDS but includes those pertaining to AIDS. To interpret 6(a) in the way the learned sessions court has will be perverse in that electrocardiograms which is common knowledge a test for heart diseases cannot be relevant to AIDS.

Fifthly, the learned sessions court judge has invoked s 114(g) of the Evidence Act against the defendant for not calling a host of witnesses. She has failed to appreciate that the relevant documents had all been agreed to. In other words there was no necessity to call the makers of such documents.

In the light of the aforesaid, I allow this appeal with costs as the alleged contract of insurance was not in existence at the time of the deceased's death and even if it was in existence, has been avoided on grounds of non-disclosure.

Appeal allowed with costs.

Reported by Moy Saw Han